DEPARTMENT OF HEALTH AND HU N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/13/11

PRINTED: 05/23/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445013	A. BUILDING _____ B. WING _____	05/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, CHATTANOOGA	2700 PARKWOOD AVE CHATTANOOGA, TN 37404

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F 159 SS=F	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the	F 159	This Plan of Correction is submitted as required under State and Federal Law. The submission of this plan does not constitute an admission on the part of NHC HealthCare, Chattanooga as to the accuracy of the Surveyors' findings nor the conclusions drawn therefrom. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. F 159 SS=F See next page...	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 6/3/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of resident trust accounts and interview, the facility failed to apply interest to eighty-eight of eighty-eight resident trust accounts reviewed. The findings included: Review of eighty-eight pooled resident trust accounts revealed no interest was applied to the trust accounts January 1, 2011, through April 30, 2011. Review of the bank account statement for the trust account for the statement period from March 1-31, 2011, revealed the average balance was $45,382.93. Interview on May 18, 2011, at 1:00 p.m., with the Business Office Manager (BOM), in the BOM's office, confirmed interest was not applied to the resident trust accounts from January 1, 2011, through April 30, 2011.	F 159	F 159 SS=F Corrective Action: 1. Interest for January 1, 2011 through April 30, 2011 will be applied to all eighty eight Resident trust accounts. To be completed by: Identifying Other Patients: 1. All residents were identified during the survey as not having interest applied to their trust account. There were no other Residents with trust accounts. Measure & Changes to be taken: 1. Bank charges will be replinished to the trust account monthly to ensure that interest accrued can be allocated to each residents account monthly. To be effective with all accounts beginning May 2011. Monitoring Performance: 1. The Business Office Manager (BOM) or designee will do a QA Studey monthly x 3 on all resident trust accounts to verify that interest earned on the trust account is allocated to all residents each month. Results will be reported monthly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 3 month monitoring, QA frequency may be reduced depending on results. To be completed by:	6/15/11 6/1/11 6/30/11
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to follow physician's orders for four residents (#18, #20, #15, #25) of twenty-eight residents reviewed. The findings included: Resident #18 was admitted to the facility on January 27, 2000, with diagnoses including Late Effects CVA (Cerebral Vascular Accident), Chronic Renal Insufficiency and Peripheral Vascular Disease. Medical record review revealed the resident received dialysis for chronic renal insufficiency at the dialysis clinic three times a week on Monday, Wednesday, and Friday. Continued medical record review revealed the resident had a vascular catheter (vas cath) placed in the upper right chest wall for dialysis access. Review of the physician's order dated May 9, 2011, revealed, "...Monitor for S/S (signs and symptoms) of bleeding at vas cath Q (every) shift..." Continued review of facility documentation revealed no evidence the facility had followed the physician's order and monitored the catheter site every shift. Interview with Licensed Practical Nurse #1 on May 18, 2011, at 4:00 p.m., at the 200 hall nurses station confirmed the physician's order had not been followed.	F 281	F 281 SS=E Corrective Action: 1. Licensed Nurses will be inserviced on monitoring the vascular catheter sight for Resident #18 as ordered by the physician. To be completed by: 2. Licensed Nurses will be inserviced on the importance and procedures in following physician orders for obtaining blood pressures when ordered on all dialysis residents which includes Residents #20 and #15. To be completed by: 3. Licensed Nurses will be inserviced on the importance of taking blood pressures prior to the administration of Clonidine for Resident #25 and other Residents who have anti-hypertensive medications where prior to administration of the medication, blood pressures are ordered. To be completed by: Identifying Other Patients: 1. All Dialysis patients records will be reviewed from 5/30/11 to 6/4/11 to ensure no other Residents were affected and that we are following Physicians orders for obtaining blood pressures. To be completed by: 2. All residents with blood pressure medications will be reviewed from 6/1/11 to 6/6/11 to ensure that no other Residents were affected and that we are following Physicians orders for obtaining blood pressures when ordered. To be completed by:	6/30/11 6/30/11 6/30/11 6/15/11 6/15/11

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F 281	Continued From page 3 Resident #20 was admitted to the facility on May 4, 2010, with diagnoses including Nephrosclerosis, Hypertension and Alzheimer's Disease. Medical record review revealed the resident received dialysis treatment three days a week on Tuesday, Thursday and Saturday. Review of the physician's order dated May 9, 2011, revealed, "...Obtain BP (blood pressure) prior to leaving for dialysis & (and) upon return from dialysis on Tues (Tuesday), Thur (Thursday), Sat (Saturday)." Review of the resident's dialysis treatment schedule revealed the first dialysis treatment after the order had been written was on May 10, 2011. Review of the facility's documentation for May 10, 2011, revealed no evidence the blood pressures had been obtained. Interview with RN #1 on May 19, 2011, at 8:30 a.m., at the 300 hall nurses station confirmed the physician's order had not been followed. Resident #15 was admitted to the facility on February 26, 2008, with diagnoses including End Stage Renal Disease, Hypertension and Diabetes. Medical record review of the physician's orders dated April 1, 2011, through April 30, 2011, and May 1, 2011, through May 31, 2011, revealed, "...Obtain v/s (vital signs) before dialysis and upon returning from dialysis..." Medical record review of the vital signs record revealed no documentation vital signs were	F 281	F 281 SS=E (continued) Measure & Changes to be taken: 1. RCC Nurse Managers will monitor Charge Nurses to ensure that blood pressures are being obtained and recorded as ordered by the Physician for Dialysis patients and for patients on blood pressure medications. 2. A new "Dialysis Return" nurses note will be initiated to better communicate the condition of each Residents return to the facility after receiving dialysis. To be completed by: 3. All Licensed Nurses will be inserviced on obtaining blood pressures and vital signs when ordered by the Physican for all Residents. To be completed by: Monitoring Performance: 1. The DON or designee will do a QA Study monthly x 2 on all dialysis residents that will include a record review to ensure that blood pressures ordered by the physician were obtained and documented in the medical record. Results will be reported monthly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by:	6/30/11 6/30/11 6/30/11

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F 281	Continued From page 4 obtained upon return from dialysis on April 8, 2011, April 18, 2011, April 20, 2011, April 22, 2011, May 4, 2011, and May 9, 2011. Interview on May 18, 2011, at 9:10 a.m., with the Assistant Director of Nursing, in the conference room, confirmed the vital signs had not been obtained upon return from dialysis on April 8, 18, 20, 22, 2011, May 4, and May 9, 2011. Resident #25 was admitted to the facility on December 7, 2005, with diagnoses including Hypertension, Hemiplegia, Cardiomegaly, and Late Effect Cerebral Vascular Accident. Medical record review of a Physician's Telephone Order dated May 10, 2011, revealed "...1.) Stop HCTZ (Hydrochlorothiazide-a diuretic medication used to control blood pressure) 2.) Clonidine (a medication used to control blood pressure) 0.1 mg. (milligram) TID (three times per day) PO (by mouth); hold for SBP (systolic blood pressure) <100 (less than 100)..." Medical record review of the May, 2011, Medication Administration Record revealed no blood pressure had been checked prior to administration of the Clonidine from the May 10, 2011, 8:00 p.m. dose through the May 18, 2011, 2:00 p.m. dose. Interview with LPN #2 on May 18, 2011, at 3:50 p.m., in nursing station three, confirmed the blood pressure had not been checked prior to Clonidine administration.	F 281	(This page intentionally blank)	
F 287 SS=D	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT	F 287		

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F 287	Continued From page 5 (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an	F 287	F 287 SS=D Corrective Action: 1. An MDS was completed and transmitted on resident #11. To be completed by: Identifying Other Patients: 1. All Resident MDS's were reviewed from 1/1/11 to 5/25/11 to identify any other MDS's as not having been completed or submitted to the State. No other Residents were affected. Completed by: Measure & Changes to be taken: 1. On or before the 10th of each month, a completed assessment report will be printed for the previous 3 months to review for timely assessments and submission of each to the state. To be effective with all residents beginning June 2011. Monitoring Performance: 1. The DON or designee will do a QA Studey monthly x 2 on all resident MDS's to verify that an MDS was completed and submitted to the state. Results will be reported monthly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by:	6/1/11 6/1/11 6/15/11 6/30/11

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F 287	Continued From page 6 initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure timely submission of the MDS (Minimum Data Set) information for one resident (#11) of twenty-eight residents reviewed. The findings included: Resident #11 was admitted to the facility on November 5, 2011, with diagnoses including Bladder Cancer, Paraplegia, Osteopenia, Scoliosis, Degenerative Joint Disease and Pressure Ulcer. Medical record review revealed no MDS available to review after December 30, 2010. Interview with the MDS Coordinator on May 17, 2011, at 4:30 p.m. at nursing station three, revealed the MDS with an assessment reference date of March 25, 2011, had not been locked or submitted to the state.	F 287	(This page intentionally blank)	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 7 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure a safety device was in place for one (#22) of twenty-eight residents reviewed. The findings included: Resident #22 was admitted to the facility on July 30, 2010, with diagnoses including Hypertension, Chronic Airway Obstruction, Hypothyroidism and Malnutrition. Medical record review of the Minimum Data Set (MDS) dated April 14, 2011, revealed the resident required extensive assistance with transfers, limited assistance with walking, and had experienced a fall since the prior assessment. Medical record review of the Complete Patient Care Plan reviewed on April 21, 2011, revealed the resident was at risk for falls and a tab alarm was to be applied when in the chair or bed. Observation on May 18, 2011, at 4:53 p.m., revealed the resident seated in a wheelchair in the resident's room. Continued observation revealed the alarm box was located on the back of the wheelchair, however, the tab alarm was not attached to the resident.	F 323	F 323 SS=D Corrective Action: 1. On 5/18/11, staff reattached the tab alarm to resident #22. 2. On 5/25/11, after observing several times since 5/18/11 that the patient disconnects the tab alarm, it was determined that the tab alarm was not an effective device for resident #22 and discontinued as a safety device. Patient continues to have a Sensormat in both her wheelchair and bed. Completed by: Identifying Other Patients: 1. On 6/2/11, all Residents with alarms and/or safety devices were checked to ensure safety devices were present, in place and working properly as care planned or as ordered by the Physician. All were in compliance. No other Residents were affected. Measure & Changes to be taken: 1. All CNA's will be inserviced on making sure safety devices are in place for each Resident as care planned. To be completed by: 2. Charge Nurses will be inserviced on the importance of checking safety devices during medication pass and on monitoring CNA's to ensure safety devices are in place for each Resident as care planned. To be completed by:	5/18/11 5/25/11 6/2/11 6/30/11 6/30/11

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F 323	Continued From page 8 Observation and interview, on May 18, 2011, at 4:57 p.m., with Licensed Practical Nurse (LPN) #3, revealed the resident seated in the wheelchair, and confirmed the tab alarm was not attached to the resident.	F 323	F 323 SS=D (continued) Monitoring Performance: 1. The DON or designee will do a QA Study monthly x 2 on 10+ Residents with safety devices that will include a visual inspection to ensure that staff followed the care plan safety instructions on each resident. Visual inspections will ensure that alarms and safety interventions are in place and working properly. Results will be reported monthly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by:	6/30/11
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of pharmacy delivery records, observation, and interview, the facility failed to ensure timely pharmacy services for one (#22) of twenty-eight residents reviewed.	F 425		

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F 425	Continued From page 9 The findings included: Resident #22 was admitted to the facility on July 30, 2010, with diagnoses including Hypertension, Chronic Airway Obstruction, Hypothyroidism and Malnutrition. Medical record review of a physician's order dated February 21, 2011, at 4:40 p.m., revealed "Gentamycin (antibiotic) opth (ophthalmic) ointment 1/2 inch Rt (right) eye TID (three times a day) X (times) 5 days." Medical record review of the nursing notes revealed the following: February 21, 2011, at 8:00 p.m., "...ABT (Antibiotic) for conjunctivitis. Gentamycin to begin to Rt. Eye..."; "February 21, 2011, at 11:00 p.m., "Med (Medication) from pharmacy Gentamycin ophthalmic did not come in from pharmacy"; February 22, 2011, at 11:00 p.m., "ABT eye ointment still did not arrive..."; February 23, 2011, at 1:00 p.m., "ABT eye oint still not in facility. Pharmacy has been notified..." Review of the pharmacy Delivery Sheets revealed the Gentamicin Ophthalmic Ointment was delivered to the facility February 23, 2011, (no time documented). Observation on May 18, 2011, at 7:15 a.m., revealed the resident lying on the bed sleeping. Interview on May 19, 2011, at 7:35 a.m., with the Director of Nursing (DON), in the conference room, confirmed the delay in obtaining the Gentamicin ophthalmic ointment.	F 425	F 425 SS=D Corrective Action: 1. The Gentamycin ophthalmic arrived on 2/23/11 for resident #22 and was administered as ordered from that date. 2. Nurses will be reinserviced about procedures on what to do if medication does not arrive timely from the Pharmacy. Completed by: Identifying Other Patients: 1. To identify any other Residents affected, all medications ordered from 6/2/11 to 6/5/11 will be reviewed to ensure that all medications were delivered and dispensed timely as ordered by the physician. To be completed by: Measure & Changes to be taken: 1. Medications that are not delivered when scheduled as ordered by the Physician are to be put on the 24 hr Nursing Report. The Charge Nurse is to call the On-Call Pharmacist and report. The Pharmacist is to make arrangements to have the medication dispensed and delivered as ordered by the Physician. If the medication is not available or not here after 24 hrs, the Physician will be notified. 2. The Pharmacy Consultant is to report on any medications not delivered and dispensed timely, as ordered by the Physician, monthly to the DON and quarterly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. To be completed by:	2/23/11 6/30/11 6/10/11 6/30/11
F 502	483.75(j)(1) ADMINISTRATION	F 502		

DEPARTMENT OF HEALTH AND HL N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445013	A. BUILDING _____ B. WING _____	05/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, CHATTANOOGA	2700 PARKWOOD AVE CHATTANOOGA, TN 37404

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F 502 SS=D	Continued From page 10 The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure laboratory tests were completed as ordered for three residents (#21, # 25, #27) of twenty - eight residents reviewed. The findings included: Resident #21 was admitted to the facility on January 29, 2011, with diagnoses including Anemia, Diabetes Mellitus and Restless Leg Syndrome. Medical record review of Physician's Telephone Orders dated April 1, 2011, revealed "...CBC (Complete Blood Count) in 1 week..." Continued review revealed an order on April 6, 2011, "...Hgb A1c (blood test done to assess blood sugar levels over a three month period) to be obtained (with) CBC see order 4/1/11..." Medical record review of the resident's chart revealed no documentation the CBC and Hgb A1c were completed on April 8, 2011. Interview with the Director of Nursing on May 19, 2011, at 8:45 a.m. in nursing station three, confirmed the CBC and Hgb A1c were not completed on April 8, 2011.	F 502	F 425 SS=D (Continued) Monitoring Performance: 1. The DON or designee will do a QA Study monthly x 2 on 10+ Residents that will include a record review to ensure that medications ordered were received and administered within 24 hrs of ordering unless otherwise ordered by the Physician. Results will be reported monthly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by: F 502 SS=D Corrective Action: 1. Resident #21 had a CBC lab completed on 5/6/11 and reviewed by the Nurse Practitioner. Resident #25 had a BMP lab completed on 4/4/11 and was reviewed by the Physicians Asst. Resident #27 had a PT/INR completed prior to discharge. Results were obtained and the resident was seen by the Nurse Practitioner. 2. Nurses will be reinserviced about the procedures on the ordering and follow through of Physician ordered labs. Completed by: 3. We are changing lab providers effective June 1st, 2011.	6/30/11 6/30/11

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F 502	Continued From page 11 Resident #25 was admitted to the facility with diagnoses including Hypertension, Hemiplegia, Cardiomegaly and Late Effect Cerebral Vascular Accident. Medical record review of Physician's Telephone Orders dated March 10, 2011, revealed "...BMP (Basic Metabolic Profile-blood test to assess blood chemistry) Dx.(Diagnosis) HCTZ (Hydrochlorothiazide-diuretic drug used to treat Hypertension) Rx. (prescription)..." Medical record review of the Medication Administration Record dated March 1-31, 2011, revealed the blood test was documented to be completed on March 11, 2011. Continued medical record review revealed a BMP had not been completed on March 11, 2011. Interview with the Assistant Director of Nursing on May 19, 2011, at 10:05 a.m., in the conference room, confirmed the BMP ordered on March 10, 2011, was not completed. Resident #27 was admitted to the facility on January 3, 2011, with diagnoses including Atrial Fibrillation, Dysphagia, Malnutrition and Congestive Heart Failure. Medical record review revealed the resident was discharged on March 14, 2011. Medical record review of a Nurse Practitioner's order dated March 7, 2011, revealed "1. increase Coumadin (anticoagulant) 6 mg (milligrams) PO (by mouth) daily. 2. PT/INR (test to check coagulopathy) on 3-11-11"	F 502	F 502 SS=D (Continued) Identifying Other Residents: 1. To identify if other Residents were affected, all Physician ordered labs from 6/1/11 to 6/6/11 will be reviewed to ensure that labs were completed and documentation is available on the medical record. To be completed by: Measure & Changes to be taken: 1. Charge Nurses are to print a Lab Log each night to review pending labs. If Labs do not come back timely, then both the Lab and Physician are contacted. 2. RCC Station Managers are to monitor Charge Nurses to make sure physician ordered labs are processed and that results are obtained and communicated timely. Monitoring Performance: 1. The DON or designee will do a QA Study monthly x 2 on 10+ Residents that will include a record review to ensure that labs ordered by the physician were processed and completed timely. Results will be reported monthly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by:	6/15/11 6/30/11

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F 502	Continued From page 12 Medical record review revealed no documentation the PT/INR was completed on March 11, 2011. Medical record review of the Nurse Practitioner's (NP) orders dated March 14, 2011, revealed "1. Discharge to...4. Home Health to manage Coumadin therapy...5. PT/INR now before discharge. 6. Call NP with results before discharge for PT/INR/Coumadin orders..." Medical record review of the PT/INR results dated March 14, 2011, revealed the PT was 12.6 and the INR was 1.3 (no reference range noted). Continued review of the PT/INR results revealed the Nurse Practitioner was notified of the results and an order was obtained to increase the Coumadin to 7 mg daily. Interview on May 18, 2011, at 8:40 a.m., with the Assistant Director of Nursing, in the conference room, confirmed the PT/INR was not completed as ordered on March 11, 2011. Interview on May 18, 2011, at 9:55 a.m., with the Nurse Practitioner, in the conference room, revealed the resident received the Coumadin due to Atrial Fibrillation and the optimal range for the resident's INR was 2.0-3.0. Continued interview revealed the Nurse Practitioner had discovered the PT/INR was not completed as ordered on March 11, 2011, and re-ordered the PT/INR on the day of discharge (May 14, 2011).	F 502	(This page intentionally blank)	